

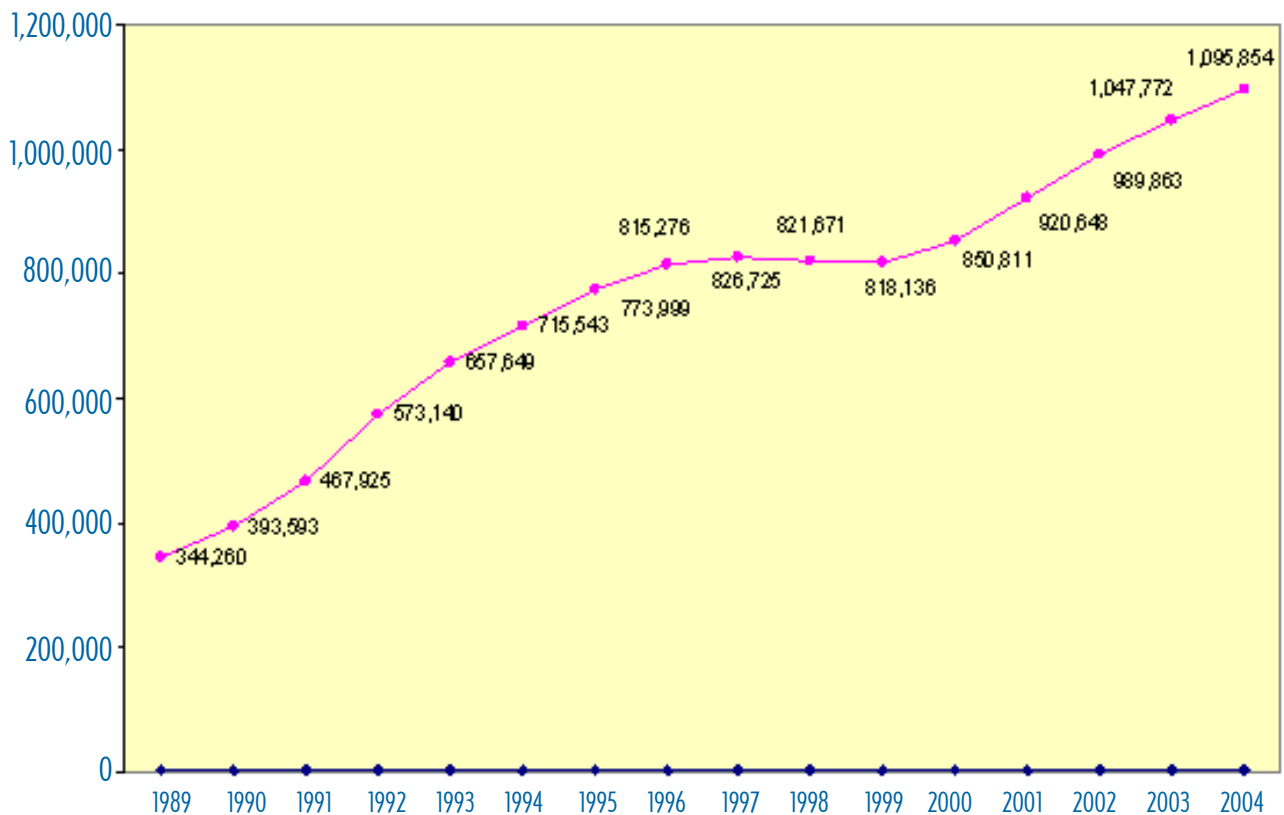
# How the NC Medicaid Program Works

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## Brief History

The State of North Carolina submitted its Medicaid State Plan to the Health Care Financing Administration in 1969 and received approval that year. General Statutes, Chapter 108A is the law that implemented Title XIX in North Carolina on January 1, 1970 under the direction of the North Carolina Division of Social Services. G.S. 108A defined certain technical aspects of the North Carolina Medicaid Program not spelled out in federal law. North Carolina Administrative Code, Title 10A, Chapters 21 and 22 provide further definition of North Carolina Medicaid policy not addressed in federal law and regulation nor state law. Each year, new legislation that is passed by the North Carolina General Assembly establishes changes to the program and its policies such as eligibility and benefit coverage expansions and contractions, management and administrative mandates, special funding, etc.

Exhibit A-1  
The History of Average Monthly Medicaid Eligibles



In 1978, the administration of the NC Medicaid Program was assigned to the newly-created Division of Medical Assistance (DMA), a separate organizational unit within the Department of Human Resources, which has since been renamed as the Department of Health and Human Services. From 1978 to 2004, the annual number of people eligible for Medicaid has increased from 456,000 to 1,512,360 (unduplicated) and Medicaid service expenditures have grown from approximately \$307 million to \$7.4 billion. As shown above, the number of average monthly eligibles has increased from 344,260 during SFY 1989 to 1,095,854 during SFY 2004.

In 36 years of operation, the programmatic complexity of Medicaid has paralleled the growth in both program expenditures and number of recipients. However, DMA has historically spent a modest percentage of its budget on administration, which during SFY 2004 was approximately \$172 million or 2 percent of total expenditures.

## Exhibit A-2 What is Medicaid?

Title XIX of the Social Security Act is a federal entitlement program that pays for medical assistance for certain individuals and families with low incomes and resources. This program, known as Medicaid, became law in 1965 as a cooperative venture jointly funded by the federal and state governments (including the District of Columbia and the Territories) to assist states in furnishing medical assistance to eligible needy persons. Medicaid is the largest source of funding for medical and health-related services for America's poorest people. Within broad national guidelines established by federal statutes, regulations, and policies, each state (1) establishes its own eligibility standards; (2) determines the type, amount, duration, and scope of services; (3) sets the rate of payment for services; and (4) administers its own program. Medicaid policies for eligibility, services, and payment are complex and vary considerably, even among states of similar size or geographic proximity. Thus, a person who is eligible for Medicaid in one state may not be eligible in another state, and the services provided by one state may differ considerably in amount, duration or scope from services provided in a similar or neighboring state. In addition, Medicaid eligibility and services within a state can change during the year.

Source: Centers for Medicare and Medicaid Services

For further general information about the Medicaid Program, eligibility and services, please refer to CMS's article "Medicaid: A Brief Summary" online at:

<http://cms.hhs.gov/publications/overview-medicare-medicaid/default4.asp>

For specific information about the NC Medicaid Program's State Plan and amendments, please refer to CMS's article "Table of Contents for the State of NC" at:

<http://cms.hhs.gov/medicaid/stateplans/toc.asp?state=NC>

## Medicaid Eligibility

Medicaid provides funding for health care to individuals who fit into one of the Medicaid coverage groups and who have low income and resources. In North Carolina, case-workers in each of the 100 county departments of social services determine an individual's eligibility for Medicaid benefits based on policies established by the federal government as implemented by the State. Eligible families and individuals enrolled in the NC Medicaid Program are issued a Medicaid identification card each month. These individuals may receive medical care from any provider enrolled in the Medicaid program. Providers submit claims to DMA for reimbursement of services they provide to the Medicaid population.

Medicaid enrollees, applicants, and caretakers who have questions regarding the NC Medicaid program, may telephone North Carolina's toll free CARE-LINE Information and Referral Service (800-662-7030). The CARE-Line forwards calls regarding covered benefits to DMA's Recipient Ombudsman Unit which ensures that questions are answered in a timely manner.

Exhibit A-3  
NC Medicaid Eligibility by Mandatory and Optional Groupings

**MANDATORY**

- Aged, Blind and Disabled persons receiving SSI
- Medicare beneficiaries up to 100% FPL qualify for Medicare cost-sharing
- Medicare beneficiaries between 101% and 135% FPL qualify for payment of Part B premium; however, total enrollment is capped by appropriated federal funds for beneficiaries with income between 121% and 135% FPL
- Pregnant women and infants (under the age of 1) up to 150% FPL
- Children ages 1 through 5 up to 133% Federal Poverty Level (FPL)
- Children ages 6 through 18 up to 100% FPL (mandatory as of October 1, 2001)
- Families with children under the age of 19 who would have been eligible for AFDC in July 1996
- Foster children and adoptive children under Title IV-E

**OPTIONAL**

- Aged, Blind and Disabled not receiving SSI, including adult care home residents, 100% of poverty eligibles and medically needy
- Pregnant women and infants up to 185% FPL
- Children ages 19 and 20
- Non-IVE foster children and/or adoptive children with parents in families not eligible under AFDC rules in July 1996 (medically needy)
- Women screened by and enrolled in the NC Breast & Cervical Cancer Control Program
- Medically needy

### Exhibit A-4 Basic Overview of Medicaid Eligibility

Who (coverage group)	Upper Income Limit	Assets (see explanation below)
Elderly Aged 65+	\$776/month single person (\$9,312 annually) \$1,041/month couple (\$12,492 annually)	\$2,000 single person \$3,000 couple
Disabled/Blind	Same as elderly	Same as elderly
Medicare Beneficiaries	\$1,048 monthly for single person (\$12,576 annually) \$1,406 monthly for couple (\$16,872 annually)	\$4,000 \$6,000
Pregnant Women and Infants	\$2,907 monthly for family of 4 (\$34,844 annually)	N/A
Children ages 1 through 5	\$2,090 monthly for family of 4 (\$25,080 annually)	N/A
Children ages 6 through 18	\$1,571 monthly for family of 4 (\$18,852 annually)	N/A
Persons aged 19 and 20	\$362 per month for single person (\$4,344 annually)	\$3,000
Parents/Caretakers	\$594 monthly for family of 4 (\$7,128 annually)	\$3,000
Medically Needy	Individuals not in the above categories qualify if they are considered to be “medically needy,” that is, very low income and/or with high medical bills. The 2004 medically needy income limit (MNIL) is \$2,904 for a family of one and \$3,804 for a family of two (eligibility is determined in six month increments). Also, those with income above this limit may still qualify if medical bills are high. Medical bills must be equal to or greater than the amount by which their income exceeds the MNIL. Eligibility begins on day the incurred medical bills equal the spend-down amount. Many recipients with a spend-down are patients in nursing homes.	\$2,000 elderly and disabled person \$3,000 for couple or family
Women who have been screened by and enrolled in the North Carolina Breast & Cervical Cancer Control Program	There is no Medicaid income or resource limit for these women. Their eligibility is solely based on the Breast & Cervical Cancer Control program screening and enrollment.	N/A
<p>The following items are not counted as assets:</p> <ul style="list-style-type: none"> <li>• Burial money</li> <li>• Home</li> <li>• Vehicle <ul style="list-style-type: none"> <li>❖ 1 vehicle for elderly, disabled/blind, and Medicare beneficiaries</li> <li>❖ 1 vehicle per adult for 19 and 20 year olds and parents/caretakers</li> </ul> </li> <li>• clothing, appliances, furniture</li> </ul> <p>In addition to financial requirements, recipients must meet the following general requirements:</p> <ul style="list-style-type: none"> <li>• NC resident</li> <li>• Citizen or “qualified alien”</li> <li>• Not incarcerated</li> <li>• Provide information on other health insurance</li> <li>• Provide Social Security Number</li> </ul>		

## Funding the NC Medicaid Program

Federal, state, and local county governments jointly finance the NC Medicaid Program, with the federal government paying the largest share of costs. In North Carolina, the 100 county governments contribute 15 percent of the non-federal share of costs. The federal share of costs for services is established annually by the Centers for Medicare and Medicaid Services (CMS). CMS calculates the rate based on the most recent three-year average per capita income for each state and the national per capita income. As North Carolina's per capita income rises, the federal match for Medicaid declines, requiring the State and the counties to increase their share of Medicaid payments.

The established federal matching rates for services are applicable to the federal fiscal year (FFY), which extends from October 1 to September 30. The State's fiscal year (SFY) runs from July 1 through June 30. Because the federal and state fiscal years are not the same, different federal service matching rates may apply for each part of the overlapped state fiscal year. The federal match rate for administrative costs does not change from year to year.

During SFY 2004, the federal government provided a special, one-time enhancement of approximately 4% in its match rate to all state Medicaid programs in order to partially compensate for the lingering negative financial impact of the recent recession.

## Administrative Contracts

Certain functions of the Medicaid program are performed under contract. Some of these functions include:

**EDS Corporation** – DMA contracts with EDS to process claims, provide billing guidance and help desk services to enrolled Medicaid providers, conduct provider education seminars, operate the prior approval system for most Medicaid services and operate the NC Medicaid Management Information System (MMIS+).

**Medical Review of North Carolina (MRNC)** – MRNC conducts quality assurance reviews of the services provided to recipients through the Community Alternatives Program for Disabled Adults (CAP/DA), Level of Care reviews for residents in Medicaid-certified nursing facilities, and the Health Maintenance Organization (HMO) contracts. MRNC also works with the DMA Program Integrity Section to 1) evaluate provider DRG coding to identify improper reimbursement maximization and other potentially incorrect billings and 2) assist in a

federal Payment Accuracy Measurement (PAM) grant to determine the accuracy rate of Medicaid claim payments. DMA's participation as one of nine grant states will help develop a process to determine a national model for all states. Payment accuracy measurement has been subsequently mandated in federal law known as the "Improper Payments Reduction Act of 2002" (Ref. HR 4878). MRNC also processes the requests for prior approval of outpatient specialized therapy services provided to Medicaid recipients. Therapy services encompass all outpatient treatment for occupational, physical, speech, respiratory and audiological therapy regardless of where the services are provided.

**ValueOptions (VO)** – DMA contracts with ValueOptions for utilization review of acute inpatient/substance abuse hospital care for recipients through age 64; Psychiatric Residential Treatment Facilities (PRTF); Levels II through IV Residential Treatment Facilities (four beds or more); and outpatient psychiatric services. The contract encompasses all elective and emergency admission reviews, concurrent continued stay reviews and post discharge reviews when applicable.

**First Health Services Corporation (FHSC)** – DMA contracts with FHSC to perform certain components of the retrospective Drug Use Review (DUR) Program. FHSC generates quarterly recipient and provider profiles from the paid claims computer tapes in accordance with the DUR Board's criteria.

**Pharmacy Prior Approval Contract** – During SFY 2002, DMA implemented a prior authorization process for certain prescription drugs through a contract with ACS State HealthCare in Atlanta, Georgia.

based on clinical criteria. Prior authorization allows NC Medicaid to ensure that these prescription drugs are used responsibly.

**Optical Contract** – Medicaid contracts with the NC Department of Correction’s Correctional Enterprises to provide eyeglasses at predetermined rates. In most cases, providers of Medicaid eye care services must obtain eyeglasses through this organization.

**Audit Contracts** – The DMA Audit Section contracts with the certified public accounting firms of Clifton Gunderson and Meyers and Stauffer to conduct onsite compliance audits of nursing facilities and intermediate care facilities for the mentally retarded (ICF-MR) who are enrolled in the Medicaid Program as well as settlement activities for hospitals and state-operated nursing facilities and ICF-MRs. These audits supplement DMA’s in-house audit activities and verify the accuracy of the providers’ cost reports.

In addition, DMA contracts with Blue Cross Blue Shield of Tennessee to perform Medicaid settlement activities for Rural Health Clinics.

## Partnerships

Although DMA administers Medicaid, other State and local agencies work closely in partnership with the program and perform important functions:

**County Departments of Social Services** – The department of social services in each of North Carolina’s 100 counties has the central role in determining Medicaid eligibility for their residents. In addition,

counties contribute approximately 5 percent of the cost of services for Medicaid patients (see Table 5 in the Tables Section of this report).

**NC Division of Social Services (DSS)** – The DSS conducts Medicaid recipient appeals when the person making the application contests eligibility denials.

**Division of Vocational Rehabilitation Services (DVR)** – DVR’s Disability Determination Unit determines whether an individual is eligible for Medicaid based on disability. This unit also makes disability determinations for two federal programs under a contract with the Social Security Administration including Title II - Social Security benefits and Title XVI - Supplemental Security Income.

**Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS)** – DMA works closely with the DMH/DD/SAS to plan for and monitor community mental health services. These agencies also work cooperatively to operate the Community Alternatives Program for persons with Mental Retardation/Developmental Disabilities (CAP-MR/DD), a valuable resource for providing community-based services as a cost-effective alternative to institutional care in an ICF-MR. Under the federal mandate for PASARR, DMH/DD/SAS staff are authorized to make the final determination for service and placement needs for all those individuals identified with MI, MR or RC diagnoses (see the “Nursing Facility Prior Approval and Retrospective Review” section of this portion of the annual report).

**Division of Public Health (DPH)** – DMA and DPH cooperate in a number of efforts to improve care for people with HIV and AIDS. The AIDS Care Unit in DPH operates HIV Case Management Services (HIV/CMS) and the Community Alternatives Programs for Persons with AIDS (CAP/AIDS). DMA and DPH also cooperate in the provision of pediatric equipment for Medicaid-eligible recipients ages birth through 20 years old.

The Women and Children’s Health Section (WCH) within DPH operates a variety of health care programs that are Medicaid-funded. WCH and local health departments also play a central role in the operation of the Baby Love Program, a care coordination program designed to assure appropriate medical care for pregnant women. It also plays a key role in the Health Check Program, which provides preventive and other health care services for children. Both programs are discussed in more detail in the “Major Initiatives and Subprograms” section of this report.

**State Center for Health Statistics (SCHS)** – The SCHS, within DPH, supports a variety of NC Medicaid’s data needs for program planning and evaluation.

**NC Office of Research, Demonstrations, and Rural Health Development** – The NC Office of Research, Demonstrations, and Rural Health Development, an agency within DHHS, provides technical assistance to small hospitals and community health centers in rural and medically under-served communities. This agency also recruits health care providers to work in rural and medically under-served communities and provides grants for community health centers and is the lead agency for demonstrations in the delivery and financing of health care for DHHS. Presently, they are working with DMA on the Community Care of North Carolina managed care program.

**Division of Aging and Adult Services (DOAAS)** – DMA and DOAAS staff work together on many issues that are important to the aged and adult population. Jointly, DMA and DOAAS design a long-range plan of services for the elderly in North Carolina. In particular, DMA staff routinely participate in policy development projects on housing and in-home aide services.

**Division of Facility Services (DFS)** – DFS has the responsibility for licensing, certifying, and monitoring facilities in North Carolina. DFS ensures that all patients, including those covered by Medicaid, receive quality care if they reside in a facility.

**Department of Public Instruction (DPI)** – The Individuals with Disabilities Education Act (IDEA) is a federal law requiring education-related services to be provided to pre-school and school aged children with special needs who are receiving special education services as part of an Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP). DMA works with DPI to provide Medicaid funding for those related services that are medically indicated, such as speech, physical, audiological and occupational therapies as well as psychological services.

**University of North Carolina at Chapel Hill (UNC-CH)** – The UNC-CH School of Public Health and the Cecil G. Sheps Center for Health Services Research have collaborated with DMA on a number of research projects and efforts to support program planning and evaluation.

**University of North Carolina at Charlotte (UNC-C)** – Faculty within UNC-C have conducted evaluations of patient satisfaction with the

Health Care Connection, NC Medicaid’s mandatory HMO program in Mecklenburg County. They have also carried out and reported on a primary care provider availability survey for Carolina ACCESS.

**NC Association of Pharmacists, NC Association of Community Pharmacists, Chain Pharmacy Committee of the NC Retail Merchants Association and the Long-Term Care Pharmacy Alliance** – These associations have entered into an agreement with DMA to reduce Medicaid drug costs. Under the agreement, pharmacists will help move patients to more cost-effective generic drugs. This will be done by educating prescribing physicians on the cost-savings that are possible through use of generic drugs and working closely with them to attain these savings as appropriate.

## Covered Services

NC Medicaid covers a comprehensive array of preventive and treatment services for eligible enrollees (see Exhibit A-5). Preventive services include one annual physical for adults and child health screenings provided under the Health Check (EPSDT) Program. Treatment services address virtually all acute and chronic illnesses.

Medicaid has certain standard limitations on services. These include a limit of 24 ambulatory visits per year to practitioners, clinics, and outpatient departments and a limit of six prescriptions per month. There are exceptions to these limits for preventive care to pregnant women, children eligible for Health Check, people with life threatening conditions, participants in the Community Alternatives Programs

(CAP), and other selected groups. Some services require nominal co-payments and others require prior approval. Both requirements ensure that the care received is medically necessary.

## Providers of Care

During SFY 2004, over 52,000 enrolled Medicaid providers offered a wide variety of services to North Carolina's Medicaid population (see Table 3). Many providers are enrolled in more than one type of service and participate with a group as well as individually. DMA's Provider Services Unit oversees the enrollment of new providers in the NC Medicaid Program and maintains licensing and credentialing information for providers enrolled with Medicaid.

During 2003, Medicaid began a policy to terminate the enrollment of providers who have not billed the Medicaid Program within the previous 12 months. Providers are notified by mail of DMA's intent to terminate their inactive number and have two weeks to respond if they wish to request that their number not be terminated. These notices are sent to the current mailing address listed in the

### Exhibit A-5 SERVICES COVERED BY NC MEDICAID BY MANDATORY AND OPTIONAL CATEGORIES

#### MANDATORY

- Hospital Inpatient
- Hospital Outpatient
- Psychiatric Residential Treatment Facility Services and Residential Services (treatment component only) for under age 21
- Other Laboratory and X-ray
- Nursing Facility
- Physician
- Home Health
- Health Check (EPSDT)
- Family Planning
- Durable Medical Equipment
- Nurse Midwife and Nurse Practitioner
- Hearing Aid
- Medical Transportation
- Federally Qualified Health Centers and Rural Health Centers

#### OPTIONAL

- Clinical
- Community Alternatives
- Diagnostic
- Intermediate Care Facilities for the Mentally Retarded
- Personal Care
- Prescription Drugs
- Dental and Dentures
- Eye Care
- Mental Health
- Chiropractor
- Podiatrist
- Physical, Occupational and Speech Therapy
- Respiratory Therapy for Children
- Hospice
- Private Duty Nursing
- Home Infusion Therapy
- Case Management
- Nurse Anesthetist
- Preventive
- Rehabilitative
- Orthotic and Prosthetic Devices
- Screening
- Transportation
- HMO Membership

**Note:** All optional services are mandatory for children under age 21 when they are medically necessary.

provider's file. Once terminated, providers are subject to the full re-enrollment process and can experience a period of ineligibility as a Medicaid provider.

This policy also addresses the problem of having an incorrect billing address in the provider's file. If remittance advices and checks cannot be delivered due to an incorrect address, all claims for the provider are suspended and the subsequent remittance advice and/or checks are no longer printed. Automatic deposits are also discontinued. Once a suspension has been placed on the provider, the provider has 90 days to submit an address change. If after 90 days the address has not been corrected, claims in suspension deny and the provider's enrollment is terminated.

Providers are notified in writing and have 21 days from the date of the letter to respond to DMA Provider Services. If the letter is returned to DMA as undeliverable, the provider's enrollment is terminated.

## Rate Setting

Payment rates and fee schedules are very important in controlling Medicaid program costs. Taking into account the level of funding provided by the N.C. General Assembly, payment rates are established according to federal and state laws and regulations. In-depth analysis of providers' cost of service is required to ensure fair and reasonable reimbursement. DMA reviews, monitors, and adjusts all reimbursement rates.

## Program Integrity

DMA's Program Integrity Section is tasked with multiple responsibilities. These include:

- Identifying fraud, abuse, waste, and administrative overpayments in Medicaid billings by health care providers
- Coordinating recipient fraud and abuse identification with the county departments of social services
- Determining the accuracy of Medicaid eligibility determinations by the county departments of social services and claim payment accuracy for claims paid by the Medicaid program.

- Collecting money and cost avoiding Medicaid payments when a third party is responsible for paying for the Medicaid service
- Ensuring, through prospective and retrospective drug use reviews, that outpatient drugs dispensed to Medicaid recipients are appropriate, medically necessary, and not likely to result in adverse medical effects.

The efforts of Program Integrity Section promote program fiscal efficiency of Medicaid money spent and the services rendered.

## Medicaid Eligibility Error Rate Reduction

Program Integrity's Quality Assurance (QA) Section is responsible for monitoring the accuracy rate of eligibility determinations made by the county departments of social services in each of North Carolina's 100 counties. The QA staff conducts both federally mandated quality control reviews and State-designed targeted reviews. This review process looks at both active and denied cases. Error trends, error-prone cases, and other important error reduction information are communicated quickly to eligibility staff. DMA then works with the counties to promote corrective actions whenever appropriate. County eligibility supervisors then conduct evaluations and training and make the necessary adjustments to eliminate errors and to prevent future mistakes.

North Carolina has never been penalized for exceeding the three percent federal tolerance level for payment error rates. North Carolina's low payment error rate is the result of a successful partnership between DMA and North Carolina's counties.

QA also coordinates with the counties on recipient fraud and abuse identification, prevention, detection, training, and recovery.

### Investigation of provider fraud, abuse or administrative errors

Program Integrity staff use sophisticated computer software in a unique fraud and abuse detection system. The software programs identify unusual patterns of utilization of services by recipients and providers. Medical desk reviews or visits are conducted for those providers or recipients whose medical practice or utilization of services appears outside comparative norms. Additionally, the staff investigates fraud complaints and allegations from many internal and external sources including calls made to the CARE-LINE to report fraud. DMA Program Integrity efforts include:

- Identifying providers and recipients who abuse or defraud the Medicaid program
- Identifying and recovering provider and recipient overpayments
- Educating providers or recipients when errors or abuse are detected
- Protecting recipients' rights
- Evaluating the medical claims processing procedures for accuracy and improvement

When an administrative overpayment is found, staff recovers it from the provider. When possible fraud or abuse is suspected, the Attorney General's Medicaid Investigations Unit reviews it for criminal or civil prosecution.

DMA operates several other programs directly or under contract to ensure that Medicaid funds are spent appropriately. These programs are designed to prevent and recover incorrect payments. DMA contracts with MRNC to evaluate DRG coding to identify improper reimbursement maximization and other potentially fraudulent billing practices. In addition, paid claims are reviewed periodically and those that differ significantly from established norms are analyzed to determine whether the services were medically necessary and appropriate.

### Third Party Recovery (TPR)

Medicaid is, by law, the payer of last resort. As a condition of receiving Medicaid benefits, recipients agree to allow Medicaid to seek payment from available third party health care resources on their behalf. All other third party resources must be used before Medicaid dollars are spent. These resources, such as health and casualty insurance and Medicare, are important means of keeping Medicaid costs as low as possible.

## Utilization Management and Prior Approval Activities

### Utilization Management

Utilization management activities ensure optimal health care delivery in a cost effective manner to Medicaid-eligible individuals. These activities are conducted jointly by the Division of Medical Assistance (DMA) and the fiscal agent or through a contract with DMA. Utilization management is used to verify medical necessity and to authorize services as well as to ensure that continuing care is provided appropriately and effectively.

### CAP Utilization Review

CAP/DA cases, randomly selected on a monthly basis from among all lead agencies for CAP, are monitored by MRNC. Quality assurance (QA) reviews determine that clients are classified correctly at either intermediate care or skilled nursing level of nursing facility care. The review also determines that clients have been given the option to choose home care versus nursing home placement, that the plan of care is relevant to the assessed needs of the clients, and that the health, safety, and well-being of clients is reasonably assured by the services provided. Results of the monthly monitorings are reviewed by DMA CAP consultants and shared with the agencies that have been reviewed. The findings enable the agencies to improve the manner in which CAP/DA is operated. The QA review process is not a negative process, but one that leads to the strengthening of programs, enabling agencies

to better serve individuals who have nursing facility needs but opt for the range of home care services available through CAP/DA.

## Prior Approval

Prior approval may be required to verify medical necessity before rendering some services. Health care providers identify the need for services that require prior approval then complete and submit the state-specified prior approval request form and any applicable supporting documentation. Services requiring prior approval include, but are not limited to:

- Long term care
- Prescription drugs
- Behavioral health
- Outpatient specialized therapies
- Managed care referral authorization and utilization management
- Certain surgeries, including transplants
- Visual aids
- Hearing aids
- Durable medical equipment
- Out-of-state services
- Nursing facilities

## Nursing Facility Prior Approval

In order for Medicaid to pay for placement in a nursing facility, an individual must meet both financial and medical eligibility requirements. The county departments of social services have the responsibility of determining financial eligibility. DMA contracts with its fiscal agent, EDS, to determine medical eligibility by utilizing a prior approval process. Prior approval does not guarantee financial eligibility or Medicaid payment.

In addition to the prior approval process, NC Medicaid is mandated to perform preadmission screening, as a part of the Preadmission Screening and Annual Resident Review (PASARR) process, for all residents applying for, or residing in, a Medicaid-certified nursing facility. This statutory requirement became effective January 1989 as a result of the Omnibus Budget Reconciliation Act (OBRA) for 1987 (P.L. 100-203). This section of OBRA was enacted to ensure that recipients with serious mental illness, mental retardation or related conditions entering into or residing in Medicaid-certified nursing facilities receive appropriate placement and services. The pre-admission screen (Level I and, if appropriate, Level II) must be completed and the special identification number, known as the PASARR number, must be documented on the state-approved prior approval form

(the FL2/FL2e). This must be completed prior to admission to a Nursing Facility.

NC Medicaid has one level of care for nursing facilities. The FL2/FL2e form is used to document information specific to the individual including diagnosis, special care needs and the PASARR number. This information is used to determine the appropriate care needs for the individual. The FL2/FL2e must be completed with current information and signed and dated by the physician and then sent to EDS to for evaluation.

Effective July 1, 2003, providers were permitted to submit FL2 information for nursing facility prior approval authorizations electronically to EDS by using a service developed by ProviderLink, Inc. This company provides web-based communications technology to enable health care providers and payors to manage all of their patient-related external communication through a single browser interface.

## Prescription Drug Prior Approval

Beginning March 4, 2002, DMA implemented a prior authorization (PA) process for certain prescription drugs through a contract with ACS State Healthcare in Atlanta, Georgia. These prescription drugs were chosen based on clinical criteria by a panel of clinical and academic physicians and pharmacists. Prior authorization allows NC Medicaid to ensure that these prescription drugs are used responsibly and as they are intended. They are:

- Drugs used to treat ADHD (for persons 19 and older)
- Procrit, Epogen
- Neupogen

- OxyContin
- Growth hormones
- Provigil
- Rebetrone
- Vioxx, Celebrex, Bextra (for persons 59 years of age or younger)
- Enbrel
- Botox, Myobloc, Zyban, Nicotrol, Habitrol
- Synagis, RespiGam (these required prior authorization beginning April 1, 2002)

### Behavioral Health Prior Approval

Prior approval is required for all psychiatric/substance abuse inpatient hospital care, all psychiatric residential treatment facility (PRTF) care for recipients under the age of 21, all residential treatment levels of care II through –IV, after 8 outpatient therapy visits for adults and after 26 outpatient visits for recipients under the age of 21. ValueOptions performs these utilization reviews.

Medicaid recipients age 21 and over receiving outpatient mental health services require prior approval after the 8th visit. This includes area mental health programs and private providers. This process replaces the policy of requesting prior approval after the 2nd visit for non-area mental health programs.

The 24-office visit limitation per year for services by a private provider was removed and replaced by the requirement for prior approval after the 8th visit for mental health services subject to independent utilization review. Approval is based on medical necessity.

### Outpatient Specialized Therapies Prior Approval

Beginning October 1, 2002, prior approval became a requirement for outpatient specialized therapy services provided to Medicaid recipients. Therapy services encompass all outpatient treatment for occupational, physical, speech, respiratory and audiological therapy regardless of where the services are provided as well as psychological services in the schools. The prior approval process for services provided in the schools is met by the IEP process. All other prior approval functions are carried out through a contract with MRNC. Based on DMA's medical policy, approved medical criteria, and medical judgment, the MRNC Prior Approval Unit is authorized to approve or deny the request. Validation reviews are performed by MRNC with review findings sent to DMA on a quarterly basis.

### Managed Care Referral Authorization and Utilization Management

Each recipient who is enrolled in Community Care of North Carolina chooses, or is assigned to, a primary care provider (PCP). The PCP serves as "gatekeeper" for the recipient in achieving the dual goals of improving access to care while reducing unnecessary costs. The PCP is expected to provide 24 hour, 7 day per week access to medical care for enrolled members and to arrange for after hours coverage and authorization for appropriate referrals for specialty care as needed. The PCP provides the referral physician with an authorization number that must appear on the medical claim to ensure Medicaid reimbursement.

From the perspective of the Managed Care Section, utilization management is a process that is used to ensure that appropriate services are delivered to Medicaid enrollees through the identification of aberrant utilization patterns and potential quality of care issues. The process provides the opportunity to identify areas to target for the development of quality improvement activities. Utilization Management also serves to provide the Managed Care Section with cost data based on service utilization, which affords cross-analysis of the efficiency and effectiveness of managed care program types.

Each Carolina Community Care of North Carolina provider receives quarterly utilization reports and monthly emergency department and referral reports. Data contained in these reports is extracted by EDS from paid claims data. These utilization reports include both inpatient and outpatient utilization statistics and are useful for peer performance comparisons. The Managed Care Quality Management Unit produces

internal reports that stratify the data according to provider specialty and the number of enrollees per provider.

Participating managed care organizations (MCOs), of which there was only one during SFY 2004, located in Mecklenburg County, are required by contract to have a written utilization management program that is consistent with federal regulations and includes mechanisms to detect under/over-utilization of services. The written description must address procedures to evaluate medical necessity, the criteria used, information sources, and the process used to review and approve the provision of medical services. MCOs are also required to submit encounter data to EDS within 90 days from the end of the month in which the service was rendered. Additionally, MCOs are required to submit HEDIS data, emergency department visits, inpatient utilization, ambulatory surgical procedures, OB discharges, and newborn data derived from their internal data collection systems to DMA on an annual basis. DMA and EDS continue to work with the sole MCO to develop an encounter reporting process that provides data that accurately reflects the delivery of services to enrollees.